MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
HEALTH FACILITY REGULATION

P.O. BOX 570
JEFFERSON CITY, MISSOURI 65102-0570

APPLICATION FOR HOSPITAL LICENSE

☐ INITIAL APPLICATION ☐ RENEWAL APPLICATION

In accordance with the requirements of the Missouri Hospital Licensing Law (sections 197.010 through 197.120, RSMo), application is hereby made for a license to conduct and maintain a hospital (see "Definitions," section 197.020, subsection 2., RSMo).

DO NOT WRITE IN THIS SPACE

LICENSE NO.

DATE

CERTIFICATE NO.

DATE MAILED

NAME OF HOSPITAL (NAME TO APPEAR ON LICENSE) | TELEPHONE NO.

ADDRESS (STREET AND NUMBER) | (CITY) | (ZIP CODE) | (COUNTY)

CHIEF EXECUTIVE OFFICER (FULL NAME) | (TITLE)

NEXT IN CHARGE (FULL NAME) | (TITLE)

TYPE OF FACILITY
☐ GENERAL HOSPITAL ☐ SPECIALTY (SPECIFY REHABILITATION, MENTAL, ETC.)

OWNERSHIP AND MANAGEMENT (CHECK ONLY ONE)

A. GOVERNMENTAL
- ☐ DISTRICT
- ☐ COUNTY
- ☐ CITY-COUNTY
- ☐ CITY
- ☐ OTHER (EXPLAIN)

B. NON-GOVERNMENTAL

NON-PROFIT
- ☐ CHURCH OPERATED
- ☐ CHURCH AFFILIATED
- ☐ OTHER NON-PROFIT

PROPRIETARY
- ☐ INDIVIDUAL
- ☐ PARTNERSHIP
- ☐ CORPORATION

NAME OF GOVERNING BODY

CHIEF OFFICER OF GOVERNING BODY (FULL NAME) | (TITLE)

LEGAL NAME OF OPERATING CORPORATION

IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM

FISCAL YEAR MO. DAY TO MO. DAY

COMPLETED AND RETURNED MOST RECENT ANNUAL SURVEY OF MISSOURI HOSPITALS? (FOR RENEWAL APPL. ONLY) ☐ YES ☐ NO

PROFESSIONAL DATA

ACTIVE STAFF ▶ NUMBER | ☐ MEDICAL ☐ OSTEOPATHIC ☐ JOINT

RADIOLOGIST (NAME) ☐ FULL-TIME ☐ PART-TIME

PATHOLOGIST (NAME) ☐ FULL-TIME ☐ PART-TIME

DIR. OF NURSING SERVICE (NAME)

DIR. MEDICAL RECORDS (NAME)

DIR. DIETARY SERVICE (NAME)

DIR. PHYSICAL PLANT (NAME)

ACCREDITED? ☐ YES ☐ NO

ACCREDITED BY ☐ JCAH ☐ AOA

APPLIED FOR ACCREDITATION? ☐ YES ☐ NO

SCHOOL OF NURSING ☐ YES ☐ NO

APPROVED FOR RESIDENT-INTERN TRAINING ☐ YES ☐ NO

NUMBER OF RESIDENTS

NUMBER OF INTERNS

BED DESIGNATION BY SERVICES (INDICATE TOTAL NUMBER OF BEDS IN EACH CATEGORY)

MEDICAL-SURGICAL	ALCOHOL/DRUG ABUSE	LTC TOTAL _____	NEONATAL ICU	OTHER (SPECIFY SERVICE)
OBSTETRICAL	PSYCHIATRIC	SKILLED NURSING _____	NURSERY BASSINETS	
PEDIATRIC	ICU-CCU	INTERMEDIATE CARE _____		
		REHABILITATION	**TOTAL BEDS**	NUMBER

NOTE: ANY CHANGES IN TOTAL BED COMPLEMENT SINCE LAST APPLICATION (INCREASE OR DECREASE) MUST BE FULLY EXPLAINED.

CERTIFICATION

STATE OF MISSOURI

City of _____ } ss.

County of _____ }

_____ and _____

CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES, OWNER, OR ONE PARTNER OR PARTNERSHIP — HOSPITAL CHIEF EXECUTIVE OFFICER

being duly sworn by me on _____ oath, deposes and says that _____ have read the foregoing application and that
HIS - THEIR — HE - THEY

the statements contained therein are correct and true and of _____ knowledge; and further gives assurance of the ability and
HIS - THEIR

intention of the _____ to comply with the regulations and codes
LEGAL NAME OF OPERATING CORPORATION

promulgated under the Missouri Hospital Licensing Law (sections 197.010 through 197.120, RSMo).

It is further certified that the _____ will comply with all recommendations
HOSPITAL NAME

for correction and/or improvements as contained in the most recent Licensing Survey Report prepared by the Department of Health and Senior Services and submitted to said Hospital.

Signed _____
CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES, OWNER, OR ONE PARTNER OF PARTNERSHIP

Signed _____
HOSPITAL CHIEF EXECUTIVE OFFICER

NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF	YEAR	**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		